New Patient Registration

MEDICAL ASSOCIATES OF BREVARD

Patient Information

Patient Name

_____

First MI Last

DOB ___/___/_____ SS# _____

Marital Status_____ ◯ MALE ◯ FEMALE

Address _____

_____

Home Phone _____ Cell _____

Work Phone _____

Employer _____

Occupation _____

Name of Spouse _____

Address: _____

_____

◯ Check if same as patient's address

Race

◯ American Indian or Alaska Native ◯ Asian
◯ Native Hawaiian ◯ Black or African American ◯ White
◯ Other Pacific Islander ◯ Prefer not to answer

Ethnicity

◯ Hispanic/Latino ◯ Non-Hispanic/Latino
◯ Prefer not to answer

Preferred Language

◯ English ◯ Spanish ◯ French ◯ Indian (includes Hindu & Tamil) ◯ Other _____

Preferred Pharmacy _____

Location _____

Family Doctor _____

Phone _____

Insurance Information

Primary Insurance Co _____

Policy #: _____

Policy holder information, if not same as patient:

Name _____

DOB ___/___/_____ SS# _____

Secondary Insurance Co _____

Policy #: _____

Policy holder information, if not same as patient:

Name _____

DOB ___/___/_____ SS# _____

Complete below if patient is a minor

Father's Name (or Guardian) _____

DOB ___/___/_____ SS# _____

Home Phone _____ Cell _____

Work Phone _____

Address: _____

_____

◯ Check if same as patient's address

Employer _____

Mother's Name (or Guardian) _____

DOB ___/___/_____ SS# _____

Home Phone _____ Cell _____

Work Phone _____

Address: _____

_____

◯ Check if same as patient's address

Employer _____

MAB
MEDICAL ASSOCIATES OF BREVARD

New Patient Registration

HIPAA Release

Patient Name

First MI Last

Do you have a Living Will? ◯ Yes ◯ No
Do you have an Advance Directive? ◯ Yes ◯ No
If you answered yes to either, please provide us a copy.

Emergency Contact:

Name Relationship

Phone #

I authorize Medical Associates of Brevard LLC to discuss my healthcare information with the below:

Name Relationship

Phone #

Name Relationship

Phone #

Preferred appointment reminder notification:
◯ Home Phone ◯ Cell ◯ Cell Text ◯ Work phone
◯ Mail ◯ E-Mail ◯ None
◯ With the person(s) authorized above

Preferred medical information notification:
I authorize Medical Associates of Brevard LLC to leave a detailed message which may contain personal health information via:
◯ Home Phone ◯ Cell ◯ Cell Text ◯ Work phone
◯ Mail ◯ E-Mail ◯ None
◯ With the person(s) authorized above

Note that authorization to contact via phone includes authorization for us to leave a message on your voicemail or answering machine.

Your HIPAA contact information will be recorded as you have indicated here. You will be asked to electronically sign to confirm this information.

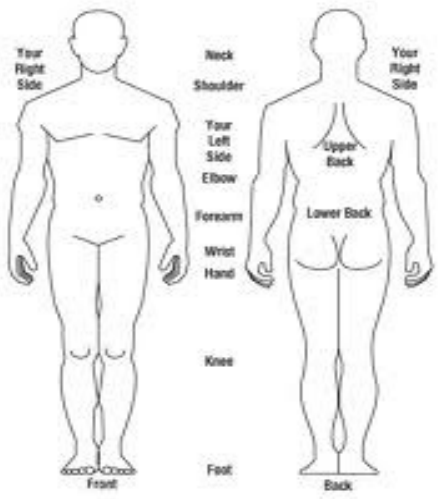
MAB-RHEUMATOLOGY
Medical Associates OF Brevard
Dr. Del Rosario, M. D.

PATIENT HISTORY FORM

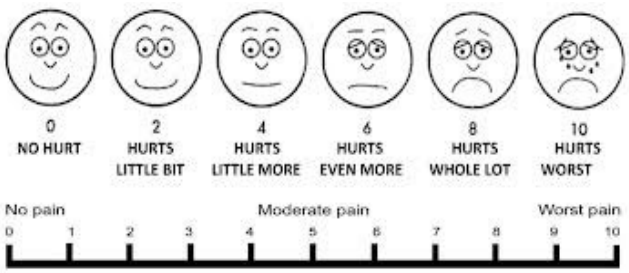
Patient Name_____ Age: _____ Occupation_____

Reason for visit_____

Do you need help with the following (Y or N): Grooming___ Dressing___ Toilet Use____ Housework_____
Preparing Meals___ Eating____ Walking____ Bathing____



Location of Pain



Level of Pain

How long has the problem been present? _____
How long does it last in normal day: _____Minutes _____ Hours _____Always present
What activities help or worsen the problem?
_____
_____
Please check quality of the problem: _____ burning _____Dull Ache _____ Sharp Pain _____Other
Does it interferes with normal daily Function: _____ Yes _____ NO

Family History

Family Member	Age (if Living)	Good Health	Poor Health	List any Illness	If deceased, cause of death	Age at death
Father						
Mother						
Brother or Sisters						

Patient Name: _____ DOB: _____

REVIEW OF THE SYSTEMS
PLACE AN X BEFORE SIGNS OF SYMPTOMS YOU PRESENTLY HAVE, OR HAVE HAD FREQUENTLY

____ ANXIETY
____ CHILLS
____ FATIGUE
____ FEVER
____ INSOMNIA
____ DRYNESS IN EYES
____ EYE PAIN
____ PAIN WHEN LOOKING AT LIGHTS (PHOTOPHOBIA)
____ VISION LOSS
____ HEARING LOSS
____ NOSE BLEEDS
____ NASAL CONGESTION
____ SINUS PAIN
____ COLD SORES
____ DRY MOUTH
____ MOUTH/TONGUE LESIONS
____ SWOLLEN GLANDS (SALIVARY GLAND ENLARGMENT)
____ SORE THROAT
____ MOUTH ULCERS
____ CLAUDICATION (COLOR CHANGES IN LIMBS)
____ IRREGULAR HEARTBEAT
____ SHORTNESS OF BREATHE (SOB)
____ CHEST PAIN
____ COUGH
____ NIGHT SWEATS
____ SNORING
____ ABDOMINAL PAIN
____ DIARRHEA
____ DIFFICULTY SWALLOWING (DYSPHAGIA)
____ REFLUX (GERD)
____ NAUSEA
____ BLOOD IN THE STOOLS
____ VOMITING
____ PAINFUL URINATION (DYSURIA)
____ BLOOD IN URINE (HEMATURIA)
____ JOINT PAIN (ARTHRALGIAS)
____ MUSCLE PAIN (MYALGIA)
____ SCIATICA
____ MORNING STIFFNESS
____ JOINT SWELLING
____ MUSCLE WEAKNESS
____ SKIN RASH
____ SKIN ULCERS
____ HAIR LOSS
____ CONFUSION
____ HEADACHES
____ LOSS OF CONSCIOUSNESS
____ NUMBNESS/TINGLING
____ DEPRESSION
____ MOOD CHANGES
____ HOT FLASHES
____ SWOLLEN LYMPH NODES (ADENOPATHY)
____ EASY BRUISING

Please List Any Previous Hospitalization And Dates (Women: do not list pregnancies)

List Any Previous Surgeries and Dates

Risk Factors:
Do you Smoke? _____ How much? _____ per day
Did you smoke previously? _____
Did you drink alcohol? _____ How often? _____
Do you use Marijuana? _____
Do you drink coffee? _____ How much? _____ per day
Have you ever used injected illegal drugs? _____ When? _____
Do you have any special diet? _____ What kind? _____
Are you currently pregnant? _____
Have you ever been pregnant_____ How many times?_____
Any Miscarriages?_____ How many?_____ Any abortions?_____
Did you have (one or more) of the following this past year?
Chest X Ray_____ Tetanus Shot_____ Hepatitis B _____
Flu shot_____ Tuberculosis Test_____ Hepatitis A _____
Blood Transfusion_____ Pneumonia Shot_____

Patient Name: _____ DOB: _____

Current Medications and dosage

1.	10
2.	11.
3.	12.
4.	13.
5.	14.
6.	15.
7.	16.
8.	17.
9.	18.

Drugs and Food Allergies

1.	4.	7.
2.	5.	8.
3.	6.	9.

Please Check Any Past Medical History

____ High blood Pressure
____ Blood Clots
____ Chronic Bronchitis
____ Fibromyalgia
____ High Cholesterol
____ Hepatitis C
____ Depression
____ Anxiety
____ Hypothyroid
____ Hyperthyroid
____ Cancer: Type _____
____ Anemia
____ Stroke
____ Tuberculosis (TB)
____ Lupus
____ Heart Attack
____ Hepatitis B
____ Seizure
____ Osteoporosis
____ Kidney Disease
____ Emphysema
____ Clots in Lungs
____ Rheumatoid Arthritis
____ Reflux/Stomach Ulcers
____ Liver Cirrhosis
____ Broken Bones
____ Diabetes: Type: _____
____ Pneumonia: Year_____
____ Gout

MAB-RHUMATOLOGY
Dr. Luis Del Rosario, M. D.

PATIENT FINANCIAL POLICY
Patient Information:
A complete and updated patient registration will be on file in the patient chart during the time in which the patient is considered an active patient. Patient registration will be updated by the office as often as it need be in the demographic information, so no sudden changes go unnoticed. A signature by the responsible party is required.

INSURANCE CLAIMS
Primary Insurance: This office will file claims with the patient's insurance upon the patient's submission of proof of insurance indicating coverage identification number and group number. In the event the patient has insurance coverage but cannot provide documentation, payment is due at time of service. Upon receipt of the insurance card, we will submit the health insurance claim form indicating patient payment at the time of service.
Secondary Insurance: Claims will be filled to secondary insurances at the time of service. However, if payment is not received in our office within 40 days after filing, the responsibility will be transferred to the patient and due upon receipt.

PATIENT FINANCIAL REPONSABILITY
If no insurance is filed or if this practice is not a participating provider, full payment is due at the time services are rendered. We will work with you to develop a payment schedule to meet your needs and ours.
Co-payments, deductibles, co-insurance and non-covered services are due at time of service. Without exceptions.
Payment arrangements will be made with a signed PAYMENT AGREEMENT and the approval of the practice manager.

MINORS/DEPENDENTS
Any patient under age of 18 will require the signature of a responsible parent or adult party on the registration form.

METHOD OF PAYMENT
Acceptable methods of payments are Cash, Checks, Visa, Master-Card and Discover.
Visa, Master-Card and Discover will be accepted by phone or fax.

ACCOUNTS PAST DUE
- Payments of financial statements are due upon receipt.
- Non-Compliance may result in submission of your account information to a collection agency and/or credit bureau and possibly a discharged from this practice.
- After 90 days an account will be turned over collections. The person financially responsible for the account will be responsible for all collection costs.
- A patient may remit in full all outstanding charges owed on account and include amounts previously place with the collection service. Under these circumstances, a physician may reserve the right to re-establish the patient to active status in the practice.

MISSED APPOINTMENTS
- This practice requires a 48 hour notice for appointment cancellation. Any appointment missed and not previously canceled will be documented and if it happens more than three times, it could result in a possible discharge from the practice
- Any appointment no canceled within 48 hours of the appointment's date will be billed to the patient as stated in the no show policy paper.

Physicians do not discuss financial issues. Our billing staff member is trained to discuss your account and make payment arrangements.

If you required your records to be sent to another physician, other than your primary doctor, there will be a fee. This fee must be paid prior to the transfer. There is no cost to provide your record to your primary doctor, but there will be a standard fee if you request copies for yourself.

I have read and understood the above stated policies.

_____ _____
Patient/Guardian Signature **Date**

_____ _____
Witness Signature **Date**

MAB-RHEUMATOLOGY
Dr. Luis Del Rosario, M. D.

NO SHOW / CANCELATION/ CO PAY POLICY

NO SHOW POLICY

It's the policy of this office to confirm 24 hours prior to the visit date. If a patient fails to show for their appointment there will be a mandatory $25.00 NO SHOW FEE without exception. If a patient fails to show 3 times without previous cancelation, this office reserves the right to discharge you from the practice.

CANCELLATION POLICY

Patients must give our office 48 hours notice to cancel or reschedule appointments. If failed to do so patient will be charged a mandatory $25.00 cancellation fee.

LATE POLICY

If a patient shows up 15 minutes or more after their schedule appointment time, the office reserves the right to reschedule the visit to another time. We will not inconvenience patients who arrive on time for their appointments.

CO-PAY POLICY

As per practice policy co-pays are due at check-in time. If the patient does not have their co-pay they will be rescheduled to another time.

I have read and understand the above stated policies.

Patient/Parent/Guardian Date

Witness Date

Print Name Date